2015-16 employee benefits guide

Dedicated Service – Every Day, for Everyone!

UNDERSTANDING YOUR BENEFITS

Contents

Your Health Is Important!

The City of Killeen wants to provide you with the freedom to select quality benefit options that work best for you.

It is important that you take an opportunity to review all of your plan options in detail. You will need to carefully consider each benefit option, its cost and value to you and whether it is appropriate for your personal need. By taking the time to examine all of your options, you will ensure that your benefits meet those needs throughout the plan year.

The City of Killeen values our employees and recognizes the importance of offering benefits that enhance people's lives. Changes have been made to add new employee benefits for 2015-2016. All benefits changes are effective October 1, 2015.

Medical/Rx Plans – Scott & White Health Plan will continue to provide access to three (3) medical/Rx plans from which employees may select. The rates for the three (3) plans will increase by +7.75% for the 2015 -2016 plan year. Please refer to the medical tab on the main page for details.

New for the 2015-2016 Plan Year - Chiropractic Care Coverage
Coverage for manipulative therapy will be covered subject to the plan benefits in which you enroll (i.e. coinsurance allowable after the calendar year deductible subject to a maximum of 35 visits per calendar year).

Dental Plan – MetLife will continue to provide the dental plan with no changes in benefits or coverage. The rates for the plan will increase by +7.00% for the 2015 -2016 plan year

Dearborn – Term Life and Accidental Death and Dismemberment

Vision Plan – NEW!! Voluntary offering by Avesis. Please refer to the vision tab on the main page for details.

Lifetime Benefit Term – NEW!! Voluntary offering by Combined Worksite Solutions
Premium for the life base insurance is guaranteed never to increase through age 100.
Fully Portable – you own it and can take it with you if you leave.
Accelerate Death Benefit for Long Term Care (LTC)

LTC benefit is 4% of the elected death benefit payable each month for up to 25 months (i.e. $50,000 Coverage provides $2,000 of LTC benefit for up to 25 months)

Texas Life – voluntary life insurance offering is back

Voluntary offerings with no changes-
Lincoln Financial Group – Accident, Critical Illness, Supplemental Term Life, and Accidental Death and Dismemberment
Guardian – Cancer
UNUM – Short-Term and Long-Term Disability

Your Health Is Important! (continued)

Benefit Advocate Center – REMINDER– The BAC is a service/benefit to help you manage your benefits. You have a single toll free number and a dedicated email address to help you in the following ways:

- Learn and understand more about your benefits – medical/Rx, dental, vision, life, and other voluntary coverage you may have elected/enrolled in.
- Help with eligibility questions including qualifying events
- Provide resolution to claims problems for all lines of coverage
- Review Explanation of Benefits (EOB) and provider billings
- Order ID cards
- COBRA questions and answers
- Assistance with appeals
- Help with finding network providers for medical/Rx, dental, and vision
- Plus much more

Benefit Resources

BENEFIT	CARRIER	MEMBER SERVICES #	WEBSITE ADDRESS
Base Plan Medical Mid Plan Medical High Plan Medical	Scott & White Health Plan	254-298-3000	www.swhp.org
Base Plan Medical Mid Plan Medical (In Area Active Employees)	Scott & White Health Plan	254-298-3000	www.swhp.org
Pharmacy - PPO	Scott & White Health Plan	254-298-3000	www.swhp.org
Dental - PPO	MetLife	800-942-0854	www.metlife.com
Basic Life/AD&D	Dearborn National	800-348-4512	www.dearbornnational.com
Voluntary Life/AD&D	Lincoln Financial	800-423-2765	www.lincolnfinancial.com
Voluntary Short Term Disability/ Long Term Disability	Unum	866-679-3054	www.unum.com
Worksite - Voluntary Critical Illness Accident Cancer	Lincoln Financial Lincoln Financial Guardian	800-423-2765 800-423-2765 888-600-1600	www.lincolnfinancial.com www.lincolnfinancial.com www.guardianlife.com
Vision	Avesis	800-828-9341 877-712-2010	www.avesis.com
Long Term Care	Combined	800-490-1322	www.combinedinsurance.com
Flexible Spending Accounts	Discovery Benefits	866-451-3399	www.discoverybenefits.com
Benefit Advocate Center (BAC)	Gallagher Benefit Services	844-828-0520	bac.cityofkilleen@ajg.com (email address)
Human Resources	City of Killeen	254-501-7837	www.killeentexas.gov
Benefit Website	Web Benefits Design	800-779-8952	www.mybensite.com/Killeen

Employee Benefits Website and Enrollment Instructions

Welcome to the City of Killeen employee benefits website! As you know, your benefits are an important part of your overall compensation. The City of Killeen is proud of our simple, convenient, online benefits enrollment system that makes enrollment faster and easier than ever before! Please visit our employee benefits website to register:

mybensite.com/killeen

New User: Once you've gained access to the site, you will be asked to register as a user on the system by creating a new user account. When creating a new user account, you must enter your last name, DOB, email address, and last 4 of SSN. You will also be asked to select a password. Once that has been completed, you will be logged into the website and gain access to the enrollment system.

Current User: Gain access to the website. Once you have gained access, you will log in with the email address and password you selected when you created a new user account. If you cannot remember your password, click on the "Forgot Password" to create a new password.

Inside the website you will find important information such as benefit summaries, forms, summary plan descriptions, provider search directories, frequently asked questions, and much more. Please review this information thoroughly before entering the Enrollment section of the website; it is important that you know and understand your benefit options BEFORE starting the enrollment process.

Please make sure your spouse is aware of this valuable resource. By providing you with this comprehensive benefits website, we want to emphasize the significant investment we are making in you. We encourage you to take advantage of all the programs and opportunities we offer.

Before You Begin:

- Please review the plan information available on this benefits website. All benefit summaries, Summary Plan Description (SPDs) and FAQs are accessible for all lines of coverage.
- If you are enrolling your spouse and/or children, please have their dates of birth and social security numbers.

Getting Started:

- To begin, select either "I don't have a user account' if you are a new user, or, if you have already registered, simply click 'Login'.
- Once you have registered, you can access the website or continue to the online enrollment site.

If you need assistance with your enrollment, please contact Katie Mathes – (254) 501-7837.

Enrollment has never been easier!

Once inside the site, you will go through a series of screens-each screen takes only a few moments to complete. All of your benefit elections will be displayed on a cost "per paycheck" basis reflecting your specific benefit options.

1) Personal Information: Please verify that all the information is accurate. If you see any blank fields or need to make changes, please update the information on this screen.

2) Dependent Information: If you have a spouse or children that you wish to cover, please enter their information in this section. Remember that you will need correct names, dates of birth, and social security numbers for all covered individuals.

3) Benefit Selections: The next few screens will present benefits selections by product (medical, dental, vision, life insurance, disability, etc.). Each page will show you the benefits you are eligible for along with a cost "per paycheck." If at any point you would like to see more information, simply click on one of the menu items to the right of the screen to see expanded benefit summaries, forms, provider links, and more. After you've made your selection, click "continue" to go to the next benefit.

4) Beneficiary Information: It is important that you complete this information. You may select a dependent from the second screen, or you may designate any other person, organization, or estate trust. We recommend updating this information on an annual basis or after any major life event.

5) Benefits Review: This is the final step. Please review your benefit choices and costs. If you wish to make changes to your selections, click on the "Edit" button to update your information. Once you have completed your review, agree to the terms and hit "Continue." You will then be given an opportunity to print a Benefits Confirmation Statement for your personal records.

WHEN CAN I ENROLL?

New Hires: You must enroll within five (5) days of attending New Hire Benefits Orientation. If you fail to enroll within your five (5) day window, you will be given the free benefits offered by the City: Scott & White Health Base Plan, Metlife Dental, and Dearborn Life and AD&D for employee only. Benefits begin the first of the month following the date of hire.

Open Enrollment: Open Enrollment is conducted annually during August and election changes are effective October 1. You may enroll and make changes online during this open enrollment season. Once open enrollment is closed, you may not make any changes to your benefit elections unless you experience a qualifying event.

If you experience a qualifying event during the plan year, you must request the appropriate changes from the Benefits Office within 30 days of the event. If you do not notify us within the 30 day time frame you will be required to wait until open enrollment to enroll or make changes.

Exclusively for City of Killeen Employees and Members

Benefit Advocate Center

Your Source for All Benefit Questions

[844] 828-0520 (Toll-Free)

Bac.cityofkilleen@ajg.com

- Explain Your Benefits [Medical, Dental, Worksite]
- Assist in answering questions about your benefits
- Helping with Eligibility Questions – waiting periods, dependent eligibility, etc.
- Provide Resolution to Claim Problems for all lines of coverage
- Explain Explanation of Benefits (EOB) and Provider billings
- Order ID Cards
  - Medical
  - Dental
- COBRA Q&A
- Assistance with Appeals
- Help with finding Network providers
  - Medical
  - Dental

PLUS MUCH MORE!

Help Is Just A Phone Call Away...

Dedicated Benefit Advocates Available
Monday – Friday between 7:30 a.m. and 5:30 p.m. (CST)
Spanish Bilingual Advocates Available

Medical Benefits Base Plan

Effective October 1, 2015

Here is a snapshot of the coverage offered through the 2015 medical plan(s). For a complete summary of medical benefits and coverage, refer to the medical page at www.mybensite.com/killeen.

SCOTT & WHITE HEALTH BASE PLAN		IN-NETWORK	OUT-OF-NETWORK
DEDUCTIBLE	Individual Family	$2,500 $5,000	$5,000 $10,000
OUT-OF-POCKET MAXIMUM (includes deductible and applicable co-pays)	Individual Family	$6,000 $12,000	$12,000 $24,000
PRIMARY CARE VISIT		$35 co-pay/visit	50% after deductible
SPECIALIST OFFICE VISIT		$60 co-pay/ visit	50% after deductible
Preventive Care (Age & Frequency Schedule Applies)		No Charge	50% after deductible
Hospital Inpatient		$500 deductible per admission plus 30% after calendar year deductible	$500 deductible per admission plus 50% after calendar year deductible
Outpatient Care		30% after deductible	50% after deductible
Emergency Room (All related charges)		$200 co-pay, plus 30% of charges	$200 co-pay, plus 30% of charges
Urgent Care Visits		$50 co-pay/visit	$50 co-pay/visit
Diagnostic X-ray (if performed as part of physician visit)		No Charge	50% after deductible
Diagnostic Lab (if performed as part of physician visit)		No Charge	50% after deductible
Diagnostic/Radiology (if performed as part of physician visit)		30% after deductible	50% after deductible
Complex Imaging (Angiograms, CT Scans, MRIs, Myelography PET scans, Stress Tests)		30% after deductible	50% after deductible
Lifetime Maximum		Unlimited	Unlimited
PRESCRIPTION DRUGS – up to 34 day/100 unit Deductible Preferred Generic Preferred Brand Name Non-Preferred Non-Formulary Specialty		At a Participating Pharmacy: $0 $10 co-pay/retail $40 co-pay/retail Lesser of $100 or 50%/retail Greater of $100 or 50%/retail 20% co-pay	At a Non-Participating Pharmacy: $50 $10 co-pay/retail $40 co-pay/retail Lesser of $100 or 50%/retail Not covered 50% co-pay
MAINTENANCE QUANTITY – up to 90 days Deductible Preferred Generic Preferred Brand Name Non-Preferred Non-Formulary Specialty		Scott & White Pharmacies Only: $0 $20 co-pay $80 co-pay Lesser of $200 or 50% Greater of $100 or 50% Not Covered	At a Non-Participating Pharmacy Pharmacies Only: $0 $20 co-pay $80 co-pay Lesser of $200 or 50% Not Covered Not Covered
PHARMACY CAVEATS		• If a brand name drug is dispensed when a generic is available then you copayment will be 50% of the cost of the drug • Specialty Drugs – Requires Prior Authorization	

Medical Benefits Mid Plan

Effective October 1, 2015

Here is a snapshot of the coverage offered through the 2015 medical plan(s). For a complete summary of medical benefits and coverage, refer to the medical page at www.mybensite.com/killeen.

SCOTT & WHITE HEALTH MID PLAN	IN-NETWORK	OUT-OF-NETWORK
DEDUCTIBLE Individual Family	$1,000 $2,000	$2,000 $4,000
OUT-OF-POCKET MAXIMUM Individual (includes deductible and applicable co-pays) Family	$3,000 $6,000	$6,000 $12,000
PRIMARY CARE VISIT	$30 co-pay/visit	40% after deductible
SPECIALIST OFFICE VISIT	$30 co-pay/visit	40% after deductible
Preventive Care (Age & Frequency Schedule Applies)	No Charge	40% after deductible
Hospital Inpatient	20% after deductible	$250 deductible per admission plus 40% after calendar year deductible
Outpatient Care	20% after deductible	40% after deductible
Emergency Room (All related charges)	$100 co-pay, plus 20% of charges	$100 co-pay, plus 20% of charges
Urgent Care Visits	$50 co-pay/visit	$50 co-pay/visit
Diagnostic X-ray (if performed as part of physician visit)	No Charge	40% after deductible
Diagnostic Lab (if performed as part of physician visit)	No Charge	40% after deductible
Diagnostic/Radiology (if performed as part of physician visit)	20% after deductible	40% after deductible
Complete Imaging (Angiograms, CT Scans, MRIs, Myelography PET scans, Stress Tests)	20% after deductible	40% after deductible
Lifetime Maximum	Unlimited	Unlimited
PRESCRIPTION DRUGS – up to 34 day/100 unit Deductible Preferred Generic Preferred Brand Name Non-Preferred Non-Formulary Specialty	At a Participating Pharmacy: $0 $10 co-pay/retail $30 co-pay/retail Lesser of $50 or 50%/retail Greater of $50 or 50% 20% co-pay	At a Non-Participating Pharmacy: $50 $10 co-pay/retail $30 co-pay/retail Lesser of $50 or 50%/retail Not covered 50% co-pay
MAINTENANCE QUANTITY – up to 90 days Deductible Preferred Generic Preferred Brand Name Non-Preferred Non-Formulary Specialty	Scott & White Pharmacies Only: $0 $20 co-pay $60 co-pay Lesser of $100 or 50% Greater of $50 or 50% Not Covered	At a Non-Participating Pharmacy Pharmacies Only: $50 $20 co-pay $60 co-pay Lesser of $100 or 50% Not Covered Not Covered
PHARMACY CAVEATS	• If a brand name drug is dispensed when a generic is available then your copayment will be 50% of the cost of drug • Specialty Drugs – Requires Prior Authorization	

Medical Benefits High Plan

Effective October 1, 2015

Here is a snapshot of the coverage offered through the 2015 medical plan(s). For a complete summary of medical benefits and coverage, refer to the medical page at www.mybensite.com/killeen.

SCOTT & WHITE HEALTH HIGH PLAN	IN-NETWORK	OUT-OF-NETWORK
DEDUCTIBLE Individual Family	$0 $0	$500 $1000
OUT-OF-POCKET MAXIMUM Individual (includes deductible and applicable co-pays) Family	$3,000 $6,000	$6,500 $13,000
PRIMARY CARE VISIT	$40 co-pay/visit	30% after deductible
SPECIALIST OFFICE VISIT	$40 co-pay/visit	30% after deductible
Preventive Care (Age & Frequency Schedule Applies)	No Charge	30% after deductible
Hospital Inpatient	10% after calendar year deductible	$250 deductible per admission plus 30% after calendar year deductible
Outpatient Care	10% after calendar year deductible	50% after calendar deductible
Emergency Room (All related charges)	$100 co-pay, plus 10% of charges	$100 co-pay, plus 10% of charges
Urgent Care Visits	$60 co-pay/visit	$60 co-pay/visit
Diagnostic X-ray (if performed as part of physician visit)	No Charge	30% after deductible
Diagnostic Lab (if performed as part of physician visit)	No Charge	30% after deductible
Diagnostic/Radiology (if performed as part of physician visit)	10% after deductible	30% after deductible
Complex Imaging (Angiograms, CT Scans, MRIs, Myelography PET scans, Stress Tests)	10% after deductible	30% after deductible
Lifetime Maximum	Unlimited	Unlimited
PRESCRIPTION DRUGS – up to 34 day/100 unit Deductible Preferred Generic Preferred Brand Name Non-Preferred Non-Formulary Specialty	At a Participating Pharmacy: $0 $5 co-pay/retail $25 co-pay/retail Lesser of $50 or 50%/retail Greater of $50 or 50% 20% co-pay	At a Non-Participating Pharmacy: $50 $5 co-pay/retail $25 co-pay/retail Lesser of $50 or 50%/retail Not Covered 50% co-pay
MAINTENANCE QUANTITY – up to 90 days Deductible Preferred Generic Preferred Brand Name Non-Preferred Non-Formulary Specialty	Scott & White Pharmacies Only: $0 $10 co-pay $50 co-pay Lesser of $100 or 50% Greater of $50 or 50% Not Covered	At a Non-Participating Pharmacy: $50 $10 co-pay $50 co-pay Lesser of $100 or 50% Not Covered Not Covered
PHARMACY CAVEATS	• If a brand name drug is dispensed when a generic is available then your copayment will be 50% of the cost of the drug • Specialty Drugs – Requires Prior Authorization	

Wellness, What Does It Mean?

We are all being asked to become more involved with our well-being, to take a more active role in managing our health and spending resources wisely. Take charge of your health the same way we take charge of our other purchases.

- When you visit the grocery store, you compare cost, nutrition, and convenience as you decide what goes into the shopping cart.
- When you buy a car, you think about driving needs, safety and reliability, gas mileage, the dealer's markup, and what you are willing to pay.
- When you buy auto insurance, you think about your driving record and decide whether you prefer to pay a lower premium for a higher deductible or a higher premium for a lower deductible.

Think about how you can apply your shopping skills to your health.

- Learn and follow the recommended preventative care for your age and gender.
- Educate yourself about how diet and activity can affect your overall health or a specific chronic condition.
- Ask your doctor for an over-the-counter medication or generic version for your prescription.
- Compare cost and quality of doctors and hospitals in your area if you need to have surgery or a medical test.
- Make yourself aware of your individual health and take advantage of the options available to you.

Health care costs are rising. Costs can vary greatly between doctors, hospitals, pharmacies, and other facilities in the same local area; brand name, generic, and over-the-counter medications; and treatment options at the emergency room, urgent care center, and your doctor's office. The cost of your care does not necessarily equal the quality of care you receive.

In order to respond to the increasing cost of insurance benefits, in FY 16 we will identify wellbeing opportunities that are intended to offset those costs while also improving our health. Those opportunities will focus on wellness and will include lunch and learns, financial workshops, preventative care sessions (annual physicals, immunizations, biometric screening, health risk assessments, etc.). This is a collaborative work-in-progress; communicating these opportunities and the path forward will continue to be our priority, with more to come.

10 Ways to Save Money

- **Pharmacy:**
  -Use generics: They do the same job as brand name with a lower co-pay
  -Mail Order: Lower co-pays for medications you take regularly

- **Urgent Care** when appropriate **vs. Emergency**
  -Lower out-of-pocket costs
  -Less wait times

- **Quit Smoking**
  -Package of cigarettes costs $5.51 – Annual savings $2,011.15
  -Enough to buy a vacation

- **Use** In-network providers

- **Lab work** – Visit with your doctor about using participating facilities.

- **Pre-tax SAVINGS:**
  Flexible Spending Account and Dependent Care Account

- **READ** your Explanation of Benefits (EOB) and doctor's bills.

- **Go for regular check-ups** – an ounce of prevention is worth a pound of cure.

- **Join** wellness programs!

- **Healthy Rewards Discounts** – Such as free gym membership to the Lion's Club Park, discounted rates for Gold's Gym, weight loss programs, vision

KNOW YOUR NUMBERS

Hopefully by now you know what your blood pressure, cholesterol, blood sugar, and BMI numbers are and if there are any risk factors. If not, now is the time to find out! In the coming year, you'll hear more about wellness screenings and how important they are to maintaining good health.

LDL Cholesterol (Bad Cholesterol)	
<100	Optimal
100-129	Near optimal/Above optimal
160-189	Borderline high
190+	Very high

HDL Cholesterol (Good Cholesterol)	
60+	Optimal, associated with lower risk for diabetes.
<40 men <50 women	Low; considered a risk factor for heart disease

Fasting Blood Sugar Level	
70 – 100 mg/dl	Optimal, associated with lower risk for diabetes.

Total Cholesterol Category	
<200	Desirable
200 – 239	Mildy High
240+	High

What is "Normal" Blood Pressure?

A blood pressure reading has a top number (systolic) and bottom number (diastolic). The ranges are:

<120 over 80 (120/80)	Normal
120 – 139 over 80 – 89	Pre-hypertension
140 – 159 over 90 - 99	Stage 1 high blood pressure

People whose blood pressure is above the normal range should consult their doctor about steps they can take to lower it.

Body Mass Index

Body mass Index (BMI) is a number calculated from a person's weight and height. BMI provides a reliable indicator of boy fatness for most people and is used to screen for weight categories that may lead to health problems.

<18.5	Under weight
18.5 to 24.9	Normal
25.0 to 29.9	Overweight
30.0+	Obese

Medical Insurance Premiums

Benefit Plan	City Cost Monthly	Employee Cost Monthly	Employee Cost Per Pay Period	Total Premium
SCOTT & WHITE HEALTH PLAN				
Base Plan				
Employee Only	$385.05	$0.00	$0.00	$385.05
Employee + Spouse	$385.05	$524.09	$262.05	$909.14
Employee + Children	$385.05	$170.11	$85.06	$555.16
Employee + Family	$385.05	$673.35	$336.68	$1,058.40
Mid Plan				
Employee Only	$385.05	$146.29	$73.15	$531.34
Employee + Spouse	$385.05	$892.59	$446.30	$1,277.64
Employee + Children	$385.05	$395.12	$197.56	$780.17
Employee + Family	$385.05	$1,103.38	$551.69	$1,488.43
High Plan				
Employee Only	$385.05	$230.72	$115.36	$615.77
Employee + Spouse	$385.05	$1,068.89	$534.45	$1,453.94
Employee + Children	$385.05	$502.73	$251.37	$887.78
Employee + Family	$385.05	$1,307.52	$653.76	$1,692.57
NATIONCARE HEALTH PLAN - IN AREA ACTIVE EMPLOYEES				
Base Plan				
Employee Only	$385.05	$38.50	$19.25	$423.55
Employee + Spouse	$385.05	$615.01	$307.51	$1,000.06
Employee + Children	$385.05	$225.62	$112.81	$610.67
Employee + Family	$385.05	$779.19	$389.60	$1,164.24
Mid Plan				
Employee Only	$385.05	$199.43	$99.72	$584.48
Employee + Spouse	$385.05	$1,020.35	$510.18	$1,405.40
Employee + Children	$385.05	$473.14	$236.57	$858.19
Employee + Family	$385.05	$1,252.23	$626.12	$1,637.28

Dental Plan

Effective October 1, 2015

For a complete summary of medical benefits and coverage, refer to the dental page at www.mybensite.com/killeen.

The City of Killeen offers all eligible employees a dental plan through MetLife.

Dental PPO Plan - MetLife

With the Dental PPO Plan through MetLife, you may see any dentist. However, in-network dentists have agreed to accept reduced fees for the services they provide.

If you receive services from an out-of-network dentist, benefits and reimbursement are based on the maximum allowable charges (MAC). The final reimbursement for out-of-network dentist will be based on the maximum allowable charges (MAC) of a network dentist. You may be responsible for the difference between out-of-network dentist billed charges minus the maximum allowable charges.

Here is a snapshot of the coverage offered through the 2016 dental plan.

	MAC PLAN	
METLIFE DENTAL PLAN	IN-NETWORK	OUT-OF-NETWORK
DEDUCTIBLE (Calendar Year) Individual Family	$50 $150	$50 $150
ANNUAL BENEFIT MAXIMUM	$1,000	$1,000
PREVENTIVE SERVICES	100% of negotiated fee	100%
BASIC SERVICES	80% of negotiated fee	80%
MAJOR SERVICES	50% of negotiated fee	50%
ORTHODONTIC SERVICES	50%; Lifetime Maximum $1,000	50%; Lifetime Maximum $1,000

How to find a dentist

To see if your provider is covered in the MetLife network or to find a PPO dentist, visit www.metlife.com and select the “Find a Provider” feature at the top of the home page.

Dental Plan (continued)

List of Primary Covered Services & Limitations

Type A - Preventive	How Many/How Often
Prophylaxis (cleanings)	• Two per 12 months.
Oral Examinations	• Two exams per 12 months • Problem focused exam 1 per 12 months.
Topical Fluoride Applications	• Two fluoride treatment per 12 months for dependent children up to 19th birthday.
X-rays	• Full mouth X-rays: one per 5 years. • Bitewing X-rays: one set per calendar year.
Sealants	• One application of sealant material every 3 years for each non-restored, non-decayed 1st and 2nd molar of a dependent child up to 16th birthday.
Type B - Basic Restorative	**How Many/How Often**
Fillings	• Replacement: once every 12 months.
Simple Extractions	
Crown, Denture, and Bridge Repair/Recementations	• Denture repair/Recementations: once per 12 months.
Endodontics	• Root canal treatment limited to once per tooth per lifetime.
General Anesthesia	• When dentally necessary in connection with oral surgery, extractions or other covered dental services.
Oral Surgery	
Periodontics	• Periodontal scaling and root planing once per quadrant, every 24 months. • Periodontal surgery once per quadrant, every 24 months. • Total number of periodontal maintenance treatments and prophylaxis cannot exceed two treatments in 12 months.
Space Maintainers	• Space Maintainers for dependent children up to 19th birthday, one per 3 years.
Type C - Major Restorative	**How Many/How Often**
Implants	• Replacement: once every 10 years.
Bridges and Dentures	• Initial placement to replace one or more natural teeth, which are lost while covered by the Plan. • Dentures and bridgework replacement: one every 10 years. • Replacement of an existing temporary full denture if the temporary denture cannot be repaired and the permanent denture is installed within 12 months after the temporary denture was installed.
Crowns/Inlays/Onlays	• Replacement: once every 10 years.
Type D - Orthodontia	**How Many/How Often**
	• Your Children, up to age 19, are covered while Dental Insurance is in effect. All dental procedures performed in connection with orthodontic treatment are payable as Orthodontia. • Payments are on a repetitive basis. • 20% of the Orthodontia Lifetime Maximum will be considered at initial placement of the appliance and paid based on the plan benefit's coinsurance level for Orthodontia as defined in the Plan Summary. • Orthodontic benefits end at cancellation of coverage.

The service categories and plan limitations shown above represent an overview of your Plan Benefits. This document presents the majority of services within each category, but is not a complete description of the Plan.

Dental Insurance Premiums

Benefit Plan	City Cost	Employee Cost		
	Monthly	Monthly	Per Pay Period	Total Premium
METLIFE DENTAL PLAN				
Employee Only	$23.52	$0.00	$0.00	$23.52
Employee + Spouse	$23.52	$23.47	$11.74	$46.99
Employee + Children	$23.52	$27.95	$13.98	$51.47
Employee + Family	$23.52	$56.51	$28.26	$80.03

MetLife®

Basic Life/Accidental Death and Dismemberment (AD&D)

Life insurance provides financial security for the people who depend on you. Your beneficiaries will receive a lump sum payment if you pass away while employed by the City of Killeen. As an eligible employee, you are covered for Base Life and Accidental Death and Dismemberment (AD&D) insurance at **no cost** to you.

www.dearbornnational.com

Dearborn National

GROUP BENEFIT PROGRAM SUMMARY
For CITY OF KILLEEN EMPLOYEE BENEFIT TRUST

The death of a family provider can mean that a family will not only find itself facing the loss of a loved one, but also the loss of financial security. With our Group Term Life plan, an employee can achieve peace of mind by giving their family the security they can depend on.

GROUP TERM LIFE

Eligibility	All Eligible Active Full Time Employees
Group Term Life/AD&D Benefit:	$15,000
Guaranteed Issue Amount – Employee	$15,000
Waiver of Premium	If an employee is unable to engage in any occupation as a result of injury or sickness for a minimum of 9 months, prior to age 60, premium will be waived for the employee's life insurance benefit until the employee is no longer disabled or reaches age 65, whichever occurs first.
Definition of Disability	Diagnosed by a doctor to be completely unable, because of sickness or injury to engage in any occupation for wage or profit or any occupation for which they become qualified by education, training or experience.
Accelerated Death Benefit (ADB)	Upon the employee's request, this benefit pays a lump sum up to 75% of the employee's Life insurance, if diagnosed with a terminal illness and has a life expectancy of 12 months or less. Minimum: $7,500. Maximum: $250,000. The amount of group term life insurance otherwise payable upon the employee's death will be reduced by the ADB.
Conversion Privilege	Included.
Beneficiary Resource Services	Includes grief, legal and financial counseling for beneficiaries.
Travel Resource Services	Helps travelers deal with the unexpected that may take place while traveling. Services include emergency medical assistance, financial, legal and communication assistance, and access to other critical services and resources available via the internet.

This information is only a product highlight. Life benefits may be subject to medical underwriting. Coverage for a medically underwritten benefit is not effective until the date the insurer has approved the employee's application. The policy has exclusions, limitations, and reduction of benefits and/or terms under which the policy may be continued or discontinued. The policy may be cancelled by the insurer at any time. The insurer reserves the right to change premium rates, but not more than once in a 12-month period.

Products and services marketed under the Dearborn National® brand and the star logo are underwritten and/or provided by Dearborn National® Life Insurance Company, (Downers Grove, IL) in all states (excluding New York), the District of Columbia, the United States Virgin Islands, the British Virgin Islands, Guam and Puerto Rico. Product features and availability vary by state and company, and are solely the responsibility of each affiliate. Refer to your certificate for complete details and limitations of coverage. (For internal use only: Policy number FDL1-504-707)

For employee distribution

Please refer to Summary of Benefits for complete benefits and coverage.

Basic Life/Accidental Death and Dismemberment (AD&D)

www.dearbornnational.com

Dearborn National

GROUP ACCIDENTAL DEATH & DISMEMBERMENT (AD&D) PROGRAM SUMMARY

Group AD&D is an additional death benefit that pays in the event a covered employee dies or is dismembered in a covered accident. AD&D benefit is 24-hour coverage.

AD&D Schedule of Loss*	Principal Sum
Loss of Life	100%
Loss of Both Hands or Both Feet	100%
Loss of One Hand and One Foot	100%
Loss of Speech and Hearing	100%
Loss of Sight of Both Eyes	100%
Loss of One Hand and the Sight of One Eye	100%
Loss of One Foot and the Sight of One Eye	100%
Quadriplegia	100%
Paraplegia	75%
Hemiplegia	50%
Loss of Sight of One Eye	50%
Loss of One Hand or One Foot	50%
Loss of Speech or Hearing	50%
Loss of Thumb and Index Finger of Same Hand	25%
Uniplegia	25%

* Loss must occur within 365 days of the accident.

AD&D Product Features Included:

- Seatbelt and Airbag Benefits
- Repatriation Benefit
- Education Benefit

Exclusions – Unless specifically covered in the policy, or required by state law, we will not pay any AD&D benefit for any loss that, directly or indirectly, results in any way from or is contributed to by:

1. disease of the mind or body, or any treatment thereof;
2. infections, except those from an accidental cut or wound;
3. suicide or attempted suicide;
4. intentionally self-inflicted injury;
5. war or act of war;
6. travel or flight in any aircraft while a member of the crew;
7. commission of, or participation in a felony;
8. under the influence of certain drugs, narcotics, or hallucinogen unless properly used as prescribed by a physician; or
9. intoxication as defined in the jurisdiction where the accident occurred;
10. participation in a riot.

This information is only a product highlight. Life benefits may be subject to medical underwriting. Coverage for a medically underwritten benefit is not effective until the date the insurer has approved the employee's application. The policy has exclusions, limitations, and reduction of benefits and/or terms under which the policy may be continued or discontinued. The policy may be cancelled by the insurer at any time. The insurer reserves the right to change premium rates, but not more than once in a 12-month period.

For employee distribution

Vision Benefits

Effective October 1, 2015

This is a snapshot of the coverage offered through the 2015-16 benefit year. For a complete summary of vision benefits and coverage, refer to the additional benefits page at www.mybensite.com/killeen.

Your vision health is an important part of complete wellness. Avesis is pleased to present your vision benefits which are designed to give you and your covered family members the care, value, and service to help maintain good vision and overall health.

AVESIS VISION PLAN	IN-NETWORK	OUT-OF-NETWORK
EYE EXAM	$10 co-pay/visit	Up to $45 Reimbursement
LENS Standard Single Vision	Covered in Full	Up to $40 Reimbursement
Standard Bifocal Lenses	Covered in Full	Up to $60 Reimbursement
Standard Trifocal Lenses	Covered in Full	Up to $80 Reimbursement
Standard Lenticular Lenses	Covered in Full	Up to $80 Reimbursement
Standard Progressive Lenses	20% off plus corresponding standard lens allowance	Up to $60 Reimbursement
Standard Specialty Lenses	20% off plus corresponding standard lens allowance	Corresponding Standard Lens Reimbursement
FRAMES	$50 Wholesale Frame Allowance ($100-150 Average Retail)	Up to $50 Reimbursement
CONTACT LENS Medically Necessary (prior authorization is required) Elective	Covered in Full $130 Allowance for materials, fit and follow-up exam	Up to $250 Reimbursement Up to $130 Reimbursement
LASIKSURGERY	5% to 20% off Retail Plus Onetime $150 Reimbursement	Up to $150 Reimbursement

BENEFIT FREQUENCY	
BENEFIT	FREQUENCY
Vision Plan	12 Months
Spectacle Lenses	12 Months
Frames	24 Months
Contact Lenses	12 Months

RATES	
Employee Only	$5.35
Employee + Spouse	$9.36
Employee + Child(ren)	$11.36
Employee + Family	$13.90

Vision Benefits (continued)

Limitations and Exclusions

Some provisions, benefits, exclusions, or limitations listed herein may vary depending on your state of residence.

Limitations: This plan is designed to cover eye examinations and corrective eyewear. It is also designed to cover visual needs rather than cosmetic options. Should the member select options that are not covered under the plan, as shown in the schedule of benefits, the member will pay a discounted fee to the participating Avesis provider. Benefits are payable only for services received while the group and individual member's coverage is in force.

Exclusions: There are no benefits under the plan for professional services or materials connected with and arising from:

1) Orthoptics of vision training;
2) Subnormal vision aids and any supplemental testing;
3) Plano (non-prescription) lenses, sunglasses;
4) Two pair of glasses in lieu of bifocal lenses;
5) Any medical or surgical treatment of eye or support structures;
6) Replacement of lost or broken lenses, contact lenses or frames, except when the member is normally eligible for services;
7) Any eye examination or corrective eyewear required by an employer as a condition of employment;
8) Services or materials provided as a result of Workers Compensation Law, or similar legislation, required by any governmental agency whether Federal, State or subdivision thereof.

Notes and Disclaimers

Notes and Disclaimers: Dilation is covered in full based on the following conditions: central vision loss, photopsia, floaters, history of ocular surgery, history of ocular trauma, history of ocular disease high myopia or diabetes. If the following conditions do not apply, members will receive Avesis' Preferred Pricing (20% off retail).

The contact lens allowance may be used all at once or throughout the plan year as needed or may be applied toward contact lenses only, or both contact lenses and professional services (fitting fees).

Laser vision correction is considered Refractive Surgery, an elective procedure, and may involve potential risks to patients. Avesis is not responsible for the outcome of any refractive surgery.

Only one co-pay applies to either frame or lenses.

Termination Provisions: Coverage will end on the earliest of: the date the policy ends, the date the employee's employment ends, or the date the employee is no longer eligible.

Insured benefits are administered by Avesis Third Party Administrators, Inc., Phoenix, AZ

Important Information

Avesis Website: **avesis.com**
Customer Service Number: **1-800-828-9341**
LASIK Provider Number: **1-877-712-2010**

Vision Benefits (continued)

Using Out-Of-Network Providers

Members who elect to use an out-of-network provider must pay the provider in full at the time of service and submit a claim to Avesis for reimbursement. Reimbursement levels are in accordance with the out-of-network reimbursement schedule previously listed. Out-of-network benefits are subject to the same eligibility, availability, frequency of benefits, and limitation and exclusion provisions of the plan and are in lieu of services provided by a participating Avesis provider. Out-of-network claim forms can be obtained by contacting Avesis' Customer Service Center,or your group administrator or by visiting www.avesis.com.

Using Your Vision Benefit

When you need to see an eye care professional, simply visit www.avesis.com or contact Avesis' Customer Service Monday through Friday, 7AM to 8PM (EST) at 1-800-828-9341 to receive a listing of providers in your area.

Using You Vision Benefit

When you need to see an eye care professional, simply visit www.avesis.com or contact Avesis' Customer Services Monday through Friday, 6AM to 7PM (CST) at 1-800-828-9341 to receive a listing of providers in your area.

1 Select a provider

2 Contact Provider for an appointment

3 Visit provider for service

4 Pay any co-pays or additional uncovered expenses

Voluntary Life & Accidental Death and Dismemberment Benefits

In addition to the Basic Life/AD&D benefit provided to you by the City of Killeen, you may purchase voluntary Life/AD&D insurance for yourself and/or your eligible dependents, through Lincoln Financial. In order to purchase voluntary Life/AD&D insurance for dependents, you must purchase voluntary life coverage for yourself.

If this is your initial enrollment period, you may elect up to the guarantee issue amount without providing evidence of insurability (EOI). If you previously waived coverage, you will be required to complete an EOI form regardless of the amount of coverage you select. Coverage will not become effective until and unless approved by Lincoln Financial.

LINCOLN FINANCIAL	SUPPLEMENTAL VOLUNTARY LIFE/AD&D
EMPLOYEE OPTION	$10,000 increments up to 7 times salary or a maximum of $500,000
NEW EMPLOYEE GUARANTEE ISSUE AMOUNT	$250,000
SPOUSE OPTION	$5,000 increments up to $250,000 not to exceed 50% of the employee's benefit amount
SPOUSE GUARANTEE ISSUE AMOUNT	$75,000
CHILD(REN) OPTION	$5,000 or $10,000, (guarantee issue $10,000)

Voluntary Short Term Disability (STD) – Unum

Voluntary Short Term Disability (STD) is designed to replace a portion of your weekly earnings due to sickness or injury. To prevent over-insurance, benefit payments are reduced by deductible sources of income. This coverage offer is through Unum.

UNUM	VOLUNTARY SHORT TERM DISABILITY
BENEFIT PERCENTAGE	60% of Your Basic Weekly Earnings
MAXIMUM WEEKLY BENEFIT	$2,500
ELIMINATION PERIOD (Injury/sickness)	Option 1: 7/7 Days Option 2: 14/14 Days
DURATION OF BENEFITS	Option 1: 25 Weeks Option 2: 24 Weeks
PRE-EXISTING CONDITION LIMITATION	3 months prior/12 months after effective date

Voluntary Long Term Disability (LTD) – Unum

Voluntary Long Term Disability (LTD) is designed to replace a portion of your weekly earnings due to sickness or injury. To prevent over-insurance, benefit payments are reduced by deductible sources of income. This coverage offer is through Unum.

UNUM	VOLUNTARY LONG TERM DISABILITY
BENEFIT PERCENTAGE	60% of Your Basic Weekly Earnings
MAXIMUM WEEKLY BENEFIT	$10,000
ELIMINATION PERIOD (Injury/sickness)	180 Days
DURATION OF BENEFITS	up to Social Security normal retirement age
PRE-EXISTING CONDITION LIMITATION	12 months prior/12 months after effective date

Please refer to Summary of Benefits for complete benefits and coverage.

Accident Plan – Lincoln Financial

Accident plan provides coverage and pays for charges when medical treatment is required as a result of an accidental bodily injury. Please refer to Summary of Benefits for complete benefits and coverage.

Benefit Type	Choice Plan	Preferred Plan
EMERGENCY CARE		
Ambulance	$150	$250
Air Ambulance	$600	$1,200
Initial Physician Office Visit	$75	$100
Emergency Room	$150	$170
Major Diagnostic Care	$100	$200
TREATMENT CARE		
Hospital Admission	$1,000	$1,300
Hospital Confinement daily benefit	$200	$250
Intensive Care unit daily benefit	$400	$600
Alternate care and rehabilitative facility daily benefit	$100	$130
Follow-up doctor/patient care up to 6 sessions	$50	$50
Transportation for care (up to 3 times per accident)	$300	$450
Companion lodging (up to 30 days per accident)	$100	$130
Family care per child up to 30 days	$20	$25
FRACTURES (per fracture)	**Non-Surgical/Surgical**	**Non-Surgical/Surgical**
Ankle, arm, collarbone, elbow, foot, hand, jaw	$600/$1,200	$1,000/$2,000
Hip	$2,800/$5,600	$3,400/$6,800
Skull (depressed)	$2,500/$5,000	$3,000/$6,000
Leg, pelvis, skull nondepressed, vertebral column	$1,500/$3,000	$1,800/$3,600
Bones of face, vertebrae, coccyx, rib, nose	$450/$900	$600/$1,200
Finger, toe	$100/$200	$250/$500
Chip Fracture	25% of fracture benefit	25% of fracture benefit
DISLOCATIONS (per injury)	**Non-Surgical/Surgical**	**Non-Surgical/Surgical**
Ankle, collarbone, sternoclavicular, foot	$800/$1,600	$1,000/$2,000
Collarbone acromio and separation, elbow, hand	$500/$1,000	$800/$1,600
Finger, toe	$150/$300	$300/$600
Hip	$2,400/$4,800	$3,000/$6,000
Knee, except kneecap	$1,500/$3,000	$1,800/$3,600
Partial dislocation	25% of dislocation benefit	25% of dislocation benefit
ACCIDENTIAL DEATH AND DISMEMBERMENT		
Employee	$75,000	$100,000
Spouse	$25,000	$50,000
Child	$12,500	$25,000
Common Carrier enhance death benefit	2 X Benefit Amount	2 X Benefit Amount
Catastrophic loss	$50,000	$80,000

Critical Illness Insurance – Lincoln Financial

Surviving a critical illness is becoming more common today, thanks to advances in medicine. With Critical Illness insurance benefits from Lincoln Financial Group, you can face your financial future with confidence and concentrate on getting better when one strikes. You have the option of purchasing coverage in increments of $10,000 to $20,000. The benefit you receive depends on the condition and the percentage of the principal sum.

Lincoln Financial	Plan Benefit
MAXIMUM PRINCIPAL SUM	
Employee	$20,000
Spouse	$10,000
Child	$10,000
GUARANTEE ISSUE AMOUNT	
Employee	$20,000
Spouse	$10,000
Child	All Guarantee Issue
HEALTH SCREENING	
Employee	$50
Family (per dependent)	$25
HEART CATEGORY	Percent of Principal Sum
Heart Attack	100%
Transplant	100%
Stroke	100%
Arteriosclerosis	10%
Aneurysm	10%
ORGAN CATEGORY	Percent of Principal Sum
End Stage Renal Failure	100%
Major Organ Transplant (excluding heart)	100%
Acute Respiratory Distress Syndrome	25%
OTHER CATEGORIES (Partial List, see Benefit Summary for complete list)	Percent of Principal sum
Severe Burn	100%
Coma	100%
Loss of Hearing	25%
Loss of Sight	25%
CANCER (Optional Coverage and a Buy-up)	Percent of Principal Sum
Invasive Cancer	100%
Cancer In Situ	25%
Benign Brain Tumor	25%
Bone Marrow Transplant	25%
PRE-EXISTING CONDITION	12/12

Example: *I buy $10,000 in coverage and then have stroke. I get paid $10,000. Alternatively, if I have an aneurysm I get paid 10% of the $10,000 or $1,000.*

Cancer Insurance – Guardian

Did you know on average out-of-pocket cost for cancer care is more than $1,200 per month? Cancer insurance can help by supplementing your medical benefit and disability income insurance. It provides a cash benefit to you based off the treatments you received related to a covered cancer diagnosis. The benefit payment to you is in addition to your medical insurance.

Guardian	Advantage Plan	Premier Plan
INITIAL DIAGNOSIS Benefit Amount (s) Employee Spouse Child Waiting Period	 $2,500 $2,500 $2,500 30 Days	 $5,000 $5,000 $5,000 30 Days
CANCER SCREENING	$75	$75
HOSPITAL CONFINEMENT	$300/Day (1st 30 Days) $600/Day (31 days+)	$400/Day (1st 30 Days) $800/Day (31 days+)
ICU CONFINEMENT	$400/Day (1st 30 days) $600/Day (31 days+)	$600/Day (1st 30 days) $800/Day (31 days+)
FEATURES (Partial List, see Benefit Summary) Ambulance Anesthesia Surgical Benefit Transportation	 $200/Trip, limit 2 per confinement 25% of surgery benefit Schedule up to $4,125 $0.50/mile up to $1,000 per round trip/equal benefit for companion	 $250/Trip, limit 2 per confinement 25% of surgery benefit Schedule up to $5,500 $0.50/mile; Up to $1,500 per round trip/equal benefit for companion
WAIVER OF PREMIUM	Included	Included
PRE-EXISTING CONDITION	6 months prior/ 12 months treatment free/ 24 months after	6 months prior/ 12 months treatment free/ 24 months after

Texas Life Insurance Company

Voluntary permanent life insurance can be an ideal complement to the group term and optional term your employer might provide. Designed to be in force when you die, this voluntary universal life product is yours to keep, even when you change jobs or retire, as long as you pay the necessary premium. Group and voluntary term, on the other hand, typically are not portable if you change jobs and, even if you can keep them after you retire, usually costs more and declines in death benefit.

The policy, PURE**LIFE**-plus, is underwritten by Texas Life Insurance Company, and it has these outstanding features:

- **High Death Benefit.** • With one of the highest death benefits available at the worksite,[1] pure**life**-plus gives your loved ones peace of mind, knowing there will be significant life insurance in force should you die prematurely.

- **Minimal Cash Value.** • Designed to provide high death benefit, pure**life**-plus does not compete with the cash accumulation in your employer-sponsored retirement plans.

- **Long Guarantees.** • [2] Enjoy the assurance of a policy that has a guaranteed death benefit to age 121 and level premium that guarantees coverage for a significant period of time (after the guaranteed period, premiums may go down, stay the same, or go up).

- **Refund of Premium.** • Unique in the marketplace, pure**life**-plus offers you a refund of 10 years' premium, should you surrender the policy if the premium you pay when you buy the policy ever increases. (Conditions apply.)

- **Accelerated Death Benefit Rider.** • Should you be diagnosed as terminally ill with the expectation of death within 12 months (24 months in Illinois), you will have the option to receive 92% (84% in Illinois) of the death benefit, minus a $150 ($100 in Florida) administrative fee. This valuable living benefit gives you peace of mind knowing that, should you need it, you can take the large majority of your death benefit while still alive. (Conditions apply.) (Form ICC07-ULABR-07 or ULABR-07)

You may apply for this permanent, portable coverage, not only for yourself, but also for your spouse, minor children, and grandchildren by answering just three questions[3]:

During the last six months, has the proposed insured:

a. been actively at work on a full time basis, performing usual duties?
b. been absent from work due to illness or medical treatment for a period of more than five consecutive working days?
c. been disabled or received tests, treatment or care of any kind in a hospital or nursing home or received chemotherapy, hormonal therapy for cancer, radiation therapy, dialysis treatment, or treatment for alcohol or drug abuse?

Texas Life Insurance Company (continued)

Like most life insurance policies, Texas Life policies contain certain exclusions, limitations, exceptions, reductions of benefits, waiting periods, and terms for keeping them in force.

Please contact a Texas Life representative for costs and complete details.

[1] Voluntary and Universal Whole Life Products, Eastbridge Consulting Group, October 2012
[2] Guarantees are subject to product terms, exclusions and limitations and the insurer's claims-paying ability and financial strength.
[3] Policies are not available for children and grandchildren in Washington.

TEXAS LIFE INSURANCE COMPANY

Combined Insurance

LifeTime Benefit Term – Champion

Life Insurance with money for long term care

Life Insurance—Powerful protection for your loved ones

You work hard to provide a good life for your family. However, what if something happens to you? If they need you, you need a champion to help defend and protect your family with money to help pay for:

- Rent and mortgage
- College education
- Retirement
- Household expenses

Make a promise to help protect the future. Let LifeTime Benefit Term (LBT) be your Champion. It lasts a lifetime—guaranteed. LifeTime Benefit Term provides money to your family at death, and while you are living too, if you need home health care, assisted living, or nursing care. Lifetime Benefit Term provides competitive rates and benefits and lasts to age 121.

- Long term care
- Childcare
- Family debt
- Burial

Innovative Benefit Design

Guaranteed Premiums

Premiums for the life base insurance will never increase and are guaranteed through age 100.

Guaranteed Benefits during Working Years

Death Benefit is guaranteed 100% when it is needed most—during your working years when your family is relying on your income. Through age 70 (or 25 years if greater), your death benefit is 100% guaranteed.

Guaranteed Benefits After Age 70

Even after age 70, when income is less relied upon, the benefit is guaranteed to never be less than 50%. Based on current interest rates, the full death benefit is designed to last a lifetime.

Paid-up Benefits

After 10 years, paid up benefit begin to accrue. At any point thereafter, if premiums stop, a reduced paid up benefit is guaranteed. Flexibility is perfect for retirement.

Long Term Care (LTC)*

If you need LTC, you can access your death benefit while you are living for home health care, assisted living, adult day care and nursing home care. After the required elimination period, you get 4% of your death benefit per month while you are living for up to 25 months to help pay for LTC. Insurance premiums are waived while this benefit is being paid.

Contingent Benefit

If your LTC rider premiums were to be increased and would cause you to lapse your coverage within 120 days of an increase, you may reduce your benefit amount without any increase in premium or convert LTC coverage to paid up status equal to 100% of all LTC rider premiums paid, or 30 times the daily nursing home benefit allowed under the LTC rider.

Combined Insurance (continued)

Here's how LifeTime Benefit Term can help be Your Family's Champion

As Life Insurance

LifeTime Benefit Term helps protect your family with money that can be used any way they choose. It is most often used to pay for mortgage or rent, education for children and grandchildren, retirement, family debt, and final expenses.

For Long Term Care

If you become chronically ill, your LifeTime Benefit Term policy will pay you 4% of your death benefit each month you receive Long Term Care. You can use this money any way you choose, and your life insurance premiums will be waived.

Your death benefit will reduce proportionately each month as you receive benefit payments for Long Term Care. Your life insurance will continue to help you protect your assets for 25 months. After 25 months of receiving Long Term Care Benefits, your death benefit will reduce to zero.

For Terminal Illness

You can receive 50% of your death benefit immediately, up to $100,000, if you are diagnosed as terminally ill.

Strong Guarantees

Life insurance provides your family with money after your death. It helps replace your income and ensure that your dependents are not burdened with debt.

Features

Strong Guarantees

Guaranteed life insurance Premium* and Death Benefits last a lifetime.

Fully Portable and Guaranteed Renewable* for Life

Your coverage cannot be cancelled as long as premiums are paid as due.

Family Coverage

Coverage available for your spouse, children and dependent grandchildren.

* LTC premiums may be adjusted based upon the experience of the group or other group characteristics that may affect results. Premiums cannot be increased solely because of an independent claim. New premiums will be based on the Insured's age and premium class on the rider's coverage date. Guaranteed life insurance Premium* and Death Benefits.

LifeTime Benefit Term Exclusions

If the insured commits suicide, while sane or insane, within two years from the Date of Issue, and while this Coverage is in force, we will pay in one sum to the Beneficiary, the amount of premiums paid for this Coverage.

Combined Insurance (continued)

Long Term Care Exclusions

We will not pay Long Term Care benefits for care that is received or loss incurred as a result of:

1. Mental or nervous conditions except Alzheimer's Disease;
2. Alcoholism and drug addiction;
3. Illness, treatment or medical conditions arising out of;
4. War or act of war (whether declared or undeclared);
5. Participation in a felony, riot or insurrection;
6. Service in the armed forces or units auxiliary thereto;
7. Suicide (sane or insane), attempted suicide, or intentionally self-inflicted injury; or
8. Treatment provided in a government facility (unless otherwise required by law), services for which benefits are available under Medicare or other Governmental program (except Medicaid), any state or federal workers' compensation, employers' liability or occupational disease law, or any motor vehicle no-fault law, services provided by a member of the covered person's immediate family, and services for which no charge is normally made in the absence of insurance.
9. Expenses for services or items available or paid under another long term care insurance or health insurance policy.
10. In the case of a qualified long term care contract, expenses for services or items to the extent that the expenses are reimbursable under Title XVIII of the Social Security Act; or would be so reimbursable but for the application of a deductible or coinsurance amount; or
11. Care or services received outside the United States or its territories.

LifeTime Benefit Term is a great way to help protect your most important asset and help provide the peace of mind your family deserves.

Flexible Spending Account

Effective October 1, 2015

This is a snapshot of the coverage offered through the 2015-16 benefit year. For a complete summary of vision benefits and coverage refer to the additional benefits page at www.mybensite.com/killeen.

The flexible spending plan is offered through Discovery Benefits. A flexible Spending Account (FSA) can provide an important tax advantage that allows you to pay certain health care and dependent care expenses on a pre-tax basis. By anticipating your family's health care and dependent care costs for the next year, you can actually lower your taxable income.

Health Care Reimbursement

This program lets employees pay for certain IRS-approved medical care expenses not covered by their insurance plan with pre-tax dollars. The annual maximum amount you may contribute to the Health Care Reimbursement FSA is $2,550. Some examples include:

- Deductible, Prescriptions, and Doctor Visit Co-Payments
- Over-the-Counter Medicines with a Prescription
- Vision services, including Lasik Eye Surgery, Glasses, and Contacts
- Hearing services, including hearing aids and batteries
- Orthodontics, Dental deductibles and coinsurance
- Acupuncture

Dependent Care FSA

The Dependent Care FSA lets employees use pre-tax dollars towards qualified dependent care such as caring for children under the age 13 or caring for elders. The annual maximum amount you may contribute to the Dependent Care FSA is $5,000 for 2015-16, (or $2,500 if married and filing separately).

Examples include:

- The cost of child or adult dependent care
- The cost for an individual to provide care either in or out of your house
- Nursery schools and preschools (excluding kindergarten)

FSA Smart Tips

- Cover any significant medical expenses early in the year using your FSA. You'll spend the remainder of the year paying yourself back with the regular payroll deductions.
- Save your receipts as proof of purchase in order to be reimbursed for your health care expenses from your FSA. So if you are making purchases that are eligible for reimbursement, you'll want to keep them separate from other items.
- Take advantage of the pre-tax savings and use your FSA dollars. Remember, unused money in an FSA at the end of the year is lost.

For more information on the FSA plan(s), please visit www.discoverybenefits.com.

Discovery Benefits
FSA • HSA • HRA • TSA • COBRA • Billing Solutions

www.DiscoveryBenefits.com
Phone: 866-451-3399 • Fax: 866-451-3245
PO Box 2926 • Fargo, ND 58108-2926
customerservice@discoverybenefits.com

Give yourself a pay raise.

Use flexible benefits to bring home more of your paycheck.

Who couldn't use a little more money? That's what you'll receive when you take advantage of a flexible spending account (FSA). An FSA allows you to set aside a portion of your salary, before taxes, to pay for qualified medical or dependent care expenses. Because that portion of your income is not taxed, you end up with more money in your pocket.

Getting money from your account is simple.

Healthcare Flexible Spending Account (FSA)

A Healthcare FSA allows you to budget and save for qualified medical expenses incurred over the course of your upcoming plan year. It is a great savings tool for you and your family. The expense must be primarily to alleviate or prevent a physical or mental defect or illness and cannot be reimbursed by insurance or any other source. Your entire election amount is available the first day of your plan year.

Eligible Expenses Include

- Prescription Medicines and Drugs
- Hearing Aids
- Orthopedic Goods, Prosthetic Devices
- Doctors
- Dentists, Orthodontics
- Osteopaths
- Chiropractors
- Optometrists, Ophthalmologists, Opticians, Eyeglasses
- Over the counter Medicines and Drugs
- Chiropodists, Podiatrists
- Nursing and Personal Care Facilities
- Medical and Dental Laboratories
- Medical Services and Health Practitioners
- Ambulance Services, Equipment and Supplies

*As of 1-1-2011 some over-the-counter items will require a doctor's prescription in order to be eligible under the FSA

Dependent Care Account (DCA)

A Dependent Care Account is a simple way to save money on care for your dependents. It allows you to set aside pre-tax dollars to pay for day care expenses. The annual IRS limit for this type of account is $5,000. If you are married and file separate returns, you can each elect $2,500 for the calendar year. To be eligible for this type of account, both you and your spouse (if applicable) must work, be looking for work or be full-time students. You may receive reimbursement up to the current balance in your account at the time the request is made.

Eligible Dependents

- Children under age 13 who are claimed as a dependent for tax purposes
- Disabled spouse or disabled dependent of any age

Ineligible Expenses

- Costs claimed as a dependent care tax credit on your tax return
- Services provided by one of your dependents
- Expenses for nighttime babysitting
- Expenses paid for school (Kindergarten and above)

View an expanded list of eligible medical expenses and information about using the Benefits debit card at:
www.discoverybenefits.com.

New Mobile Application

Discovery Benefits is proud to introduce the new Discovery Benefits Mobile Application for iPhone (including iPad, iPod, and iTouch) and Android devices.

- Password protected
- No information stored on your phone
- Check account balance(s)
- Upload receipts
- View final filing dates
- View claim detail
- Contact customer service
- Text alert options

Discovery Benefits
FSA • HSA • HRA • TSA • COBRA • Billing Solutions

www.DiscoveryBenefits.com
Phone: 866-451-3399 • Fax: 866-451-3245
PO Box 2926 • Fargo, ND 58108-2926
customerservice@discoverybenefits.com

Guide to the Benefits Debit Card

Advantages of the Discovery Benefits Debit Card

Less out-of-pocket expenses at the time of service
No waiting for reimbursement
Merchant is paid directly at the point of sale
Increased use of funds, less chance to forfeit at the end of the year
Benefits Debit Card is valid for three years

How It Works:

- Use the Discovery Benefits Debit Card to pay for eligible services and products.
  Payments are automatically withdrawn from your reimbursement account, so there are less out-of-pocket costs. Merchants with the Inventory Information Approval System (IIAS) can provide all IRS-required information right at the point of sale. Your debit card will also work at pharmacies and drug stores that meet the IRS' 90% rule. Documentation needs to be provided for purchases made at a 90% merchant. An IIAS and 90% merchant list can be located on our website at www.discoverybenefits.com.

- PIN numbers can be set up for your Benefits Debit Card. In order to set up a PIN number, please call Discovery's automated response system at 866.451.3399, option 1 to identify that you are a participant, option 1 to identify which plan and option 3 to select PIN. Please have your card available for reference in order to expedite the process. ***Note:*** HSAs are exempt from this PIN process. PINs will only allow you to pay for eligible goods and services at the point-of-sale; cash-back and ATM transactions will not be allowed.

Documentation/Receipts:

- Due to IRS regulations, certain debit card transactions need to be substantiated. Substantiating means validating a transaction to ensure the debit card was used for IRS approved items/services within the allowed time frame. If documentation is required for a debit card transaction you will receive email notifications to log in to your account to view Receipt Reminders. The Receipt Reminder will display the documentation required and your next steps.
  ***If you do not have an email address on file, a Receipt Reminder will be mailed.*

- Debit card use will be put on temporary hold if documentation is not received within the designated time period. You will be asked to pay back the plan or offset the ineligible amount with documentation for eligible out-of-pocket expenses incurred within the same plan year. The Benefits Debit Card will be reactivated as soon as the appropriate documentation or repayment is received.

When Documentation Is Not Needed:

- Co-payments tied to the account holder's health plan. These amounts need to be communicated to Discovery Benefits by your employer.

- Purchases made at merchants using the Inventory Information Approval System (IIAS). These merchants will approve eligible expenses at the point of purchase. When using your debit card at these merchants, swipe your debit card for the entire purchase. The items that are eligible expenses will be approved, and the merchant will ask for a secondary form of payment for ineligible items. To find a full list of merchants utilizing IIAS, visit our website at www.discoverybenefits.com/extras or click the link at the bottom of this document.

- Recurring expenses that match the same provider and dollar amount for previously substantiated transactions. (e.g., orthodontia claims, maintenance prescription drugs/services).

When Documentation Is Needed:

- Debit card transactions that do not meet the above criteria will need additional documentation due to IRS regulations. If documentation is required for a debit card transaction you will receive email notifications to log in to your account to view Receipt Reminders. The Receipt Reminder will display the documentation required and your next steps. ***If you do not have an email address on file, a Receipt Reminder will be mailed.*

Documentation Requirements:

- Documentation for **medical expenses**, which is required by the IRS, includes a receipt/statement containing: name of the provider, date(s) of service, type(s) of service and amount (after insurance, if applicable). Explanation of Benefits (EOB) provided by insurance provider are ideal for substantiating claims.
    - When submitting a receipt for a co-payment amount, please be sure the co-payment description is on the receipt. In some cases, you will need to ask for a receipt at the point of service. If "co-payment" is not clearly identified, have the provider write "co-payment" on the receipt and sign it.

- Documentation for **dependent care expenses**, which is required by the IRS, includes a receipt containing: name of provider, date(s) of service, type(s) of service and dollar amount. NOTE: The daycare provider's signature on the Receipt Reminder will replace the need to submit a receipt.

Unacceptable forms of documentation include the following:

- Provider statements that only indicate the amount paid, balance forward or previous balance
- Credit card receipt
- Missing or vague medical practitioner's note
- Bills for prepaid dependent care/medical expenses where services have not yet occurred

How to Submit Documentation:

Documentation can be uploaded by logging in to your account at www.discoverybenefits.com or by using the mobile app feature. If you chose to fax your documentation, please include the Receipt Reminder. Processing time is two business days; if further action is required, you will be notified in writing. Documentation is processed on a Central Time zone basis.

Participant Services – Hours of Operations	7:00 a.m. to 7:00 p.m. CT (M-F)
Participant Services Toll-Free Phone Number	866-451-3399
Mailing Address	Discovery Benefits PO Box 2926 Fargo, ND 58108
Participant Services Toll-Free Fax Number	866-451-3245
Participant Services Email Address (inquires only, please do not submit documentation to this address)	customerservice@discoverybenefits.com

Have a Medical FSA balance and want to avoid submitting receipts? Learn how to easily manage your account, spend down your balance, and find a full list of merchants that utilize IIAS at our website:

Visit Our Website

695

Discovery Benefits®
simplify.℠

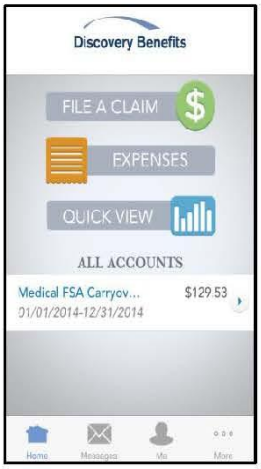
The Discovery Benefits Mobile Application

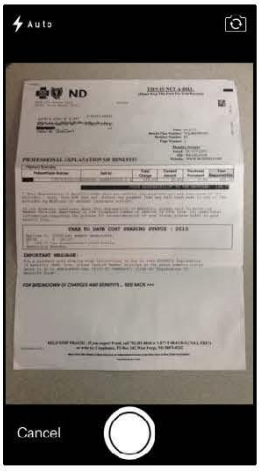
Check out the Discovery Benefits Mobile Application for iPhone, iPad and Android devices. It's never been easier or more convenient to access your account information. Our App allows you to upload receipts, check your balances, view final filing dates, access claim detail, contact customer service, report a lost or stolen debit card, reset your password and even file a claim.

The data transfer is secure as we utilize 128-bit SSL on all mobile transmissions and a passcode is required each time you enter the App. No pictures are stored on the phone, so you can rest assured that your information is safe.

The Discovery Benefits Mobile Application will simplify how you use your Flexible Spending Account, Health Savings Account, Parking/Transit Account or Health Reimbursement Arrangement. Get the App today - available FREE in the iTunes Store and Google Play Store.

Upload Receipts - Check Balances – File Claims - View Filing Dates - Contact Us - Secure Transmission





457 Deferred Retirement Account

ICMA

A 457 deferred compensation plan allows you to save and invest money for retirement with tax benefits.

Contributions are made to an account in your name for the exclusive benefit of you and your beneficiaries. The value of the account is based on the contributions made and the investment performance over time.

A 457 plan is designed to supplement your retirement income. While a pension and/or Social Security may go a long way, they are unlikely to be enough. Saving to your 457 plan can help you maintain your desired standard of living.

Contributions

Pre-tax contributions you make reduce your taxable income for the year. These contributions and all associated earnings are then not subject to tax until you withdraw them. You also may be able to make after-tax Roth contributions which allow for potentially *tax-free* earnings.
Contribution limits apply - for 2015, you can contribute up to $18,000, up to $24,000 if you are age 50 or over, or up to $36,000 if you qualify for pre-retirement catch-up contributions.
To contribute to your 457 plan or change the amount of your current contributions, contact your employer or your ICMA-RC representative for instructions, including whether you can submit these completed ICMA-RC forms to your employer:

- 457 Plan Enrollment Form - to participate for the first time.
- Contribution Change Form - to resume contributions if you previously enrolled, or to increase or decrease current contributions.

Investments

You control how your account is invested, choosing from options selected by your employer.
A typical plan includes a wide range of options, from more conservative stable value funds and CDs to more aggressive bond and stock funds. You may choose to build a diversified portfolio of various funds, select a simple yet diversified target-date or target-risk fund, or rely on specific investment advice through Guided Pathways.

- To review investment options for your plan, login to your account.
- To learn more about investing for retirement, visit www.icmarc.org/invest.

Withdrawals

You can make withdrawals from your account when you leave employment. You have the ability to take payments as needed or request scheduled automatic payments. You maintain control over your investments and continue to benefit from tax deferral even after you leave your employer. During employment, subject to your employer and IRS rules, you may also be able to make withdrawals after age 70½ or due to an unforeseeable emergency. A loan option may also be available.

Withdrawals are generally taxable but, unlike other retirement accounts, the 10% penalty tax does not apply to distributions prior to age 59½ (the penalty tax may apply to distributions of assets that were transferred to the 457 plan from other types of retirement accounts). For detailed tax information, view Special Tax Notice Regarding Plan Payments.
Have a plan for taking withdrawals from your account - both to manage the tax bill and to provide for your future needs. For guidance, view Making a Smart Withdrawal Decision and our RealizeRetirement website, or contact your ICMA-RC representative.

457 Deferred Retirement Account (continued)

To request a withdrawal from your ICMA-RC account:

- Log in to your account to see if your employer allows online withdrawals. Select Withdraw Funds from the left-hand menu.
- Or, complete and submit the forms in the 457 Plan Benefit Withdrawal Packet. To obtain a copy, contact Investor Services.

Survivor Benefits

You designate a beneficiary, or beneficiaries, to receive any remaining assets upon your death. Designating beneficiaries can help ensure your assets are paid per your wishes, avoid the potential costs and delays of probate, and allow non-spouse beneficiaries to receive additional tax benefits.

NATIONWIDE

Deferred compensation plans, also known as 457 retirement plans are designed for state and municipal workers and employees of some tax-exempt organizations.

If you participate in a 457 plan, you can contribute a portion of your salary to a retirement account. That money and any earnings you accumulate are not taxed until you withdraw them.

With a 457 retirement savings plan:

- There isn't a minimum retirement age
- There isn't a 10% federal penalty for early withdrawal of funds, although withdrawals are subject to ordinary income taxes
- There is a withdrawal option for unforeseen emergencies that meet certain legal criteria, if all other financial resources are exhausted

Distributions are available in a lump sum, annual installments or as an annuity. There is no tax withholding if you leave for a new job and roll over your money into an IRA or your new employer's 401(k), 403(b) or 457 plan – or if you take regular installments for 10 years or more. (All other distributions are subject to 20% withholding for federal taxes.)

Keep in mind that federal income tax laws are complex and subject to change. Neither Nationwide nor our representatives give legal or tax advice. Please consult your attorney or tax advisor for answers to specific questions.

What Constitutes a Qualifying Life Event?

Qualifying Life Event	Medical	Dental	Suppl EE Life	Suppl Spouse Life	Suppl Child Life	FSA Medical	FSA Dependent Care	Beneficiaries	
Change in marital status: • Marriage • Divorce or Annulment • Legal Separation • Death of Spouse	✓	✓		✓		✓	✓	✓	Marriage Certificate Divorce Decree Final Court Document Notarized Statement of Disenrollment Death Certification
Change in the number of dependents: • Birth • Adoption • Guardianship of a Child • Death of a Dependent	✓	✓			✓	✓	✓	✓	Birth Certificate Hospital Announcement Adoption Agreement Court Decree for Guardianship Death Certificate
Dependent Becomes Eligible	✓	✓	✓	✓	✓	✓	✓	✓	Provide Name, Social Security Number, and Date of Birth for dependents
Dependent Loses Other Coverage	✓	✓				✓	✓	✓	Proof of Loss of Coverage, such as termination letter; Certificate of Credible Coverage
Dependent Gains Other Coverage	✓	✓				✓	✓	✓	Proof of Coverage with start date of benefits and name(s) of covered dependents
A change in Employee's, spouse's, or dependent's work hours (including a switch between full and part-time status)	✓	✓				✓	✓	✓	Proof of loss of Coverage due to employment status change, such as Certificate of Credible Coverage or letter from the company
Change in Dependent Care Costs							✓		Letter from your Day Care Provider
Court Ordered Dependent, add or drop from coverage	✓	✓			✓	✓	✓	✓	Contact your Benefits Team Directly

Annual Notices

Health Insurance Portability and Accountability Act (HIPAA) requires a group health plan to provide a Notice of Special Enrollment Rights annually to all employees who are eligible to participate in the plan.

Notice of Special Enrollment Rights

Loss of Other Coverage - If you are declining enrollment for yourself and/or your dependents (including your spouse) because of other health insurance coverage or group health plan coverage, you may be able to enroll yourself and/or your dependents in this plan if you or your dependents lose eligibility for that other coverage or if the employer stops contributing towards you or your dependent's coverage. To be eligible for this special enrollment opportunity you must request enrollment **within 30 days** after your other coverage ends or after the employer stops contributing towards the other coverage.

New Dependent as a Result of Marriage, Birth, Adoption or Placement for Adoption - if you have a new dependent as a result of marriage, birth, adoption or placement for adoption, you may be able to enroll yourself and/or your dependent(s). To be eligible for this special enrollment opportunity, you must request enrollment **within 30 days** after the marriage, birth, adoption or placement for adoption.

The **City of Killeen Group Health Plan** will allow an employee or dependent who is eligible, but not enrolled, for coverage to enroll for coverage if either of the following events occur:

Medicaid Coverage:

1. TERMINATION OF MEDICAID OR CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP) COVERAGE- If the employee or dependent is covered under a Medicaid plan or under a State child health plan and coverage of the employee or dependent under such a plan is terminated as a result of loss of eligibility.

2. ELIGIBILITY FOR PREMIUM ASSISTANCE UNDER MEDICAID OR CHIP- If the employee or dependent becomes eligible for premium assistance under Medicaid or a State child health plan, including under any waiver or demonstration project conducted under or in relation to such a plan. This is usually a program where the state assists employed individuals with premium payment assistance for their employer's group health plan rather than direct enrollment in a state Medicaid program.

To be eligible for this special enrollment opportunity you must request coverage under the group health plan within 30 days after the date the employee or dependent becomes eligible for premium assistance under Medicaid or CHIP or the date you or your dependent's Medicaid or state-sponsored CHIP coverage ends.

To request special enrollment or obtain more information, please contact the Human Resources Department.

Annual Notices (continued)

Health Insurance Portability and Accountability Act (HIPAA)

The City of Killeen in accordance with HIPAA, protects your Protected Health Information (PHI). **The City of Killeen** will only discuss your PHI with medical providers and third party administrators when necessary to administer the plan that provides your medical and dental benefits or as mandated by law.

HIPAA Privacy Notice Update

HIPAA requires **The City of Killeen** to notify you that the Privacy Notice is available from the HR Department. To request a copy of the **City of Killeen's** Privacy Notice or for additional information, please contact the HR Department.

Pre-Tax Contributions

In most cases, the **City of Killeen** employees' contributions for medical, dental and vision coverage's are deducted from their paychecks on a pre-tax basis, meaning before federal income tax is calculated. Internal Revenue Code (I.R.C.) Section 152 defines what dependent contributions are eligible for pre-tax deductions. The IRS does not allow employees' contributions for dependent health coverage to be deducted on a pre-tax basis unless the dependent(s) meet the definition of a tax dependent under I.R.C. Section 152. If they do not meet the definition of a tax dependent, they may be either ineligible for the Plan, or in some cases, the IRS taxes the additional fair market value of these benefits and treats it as Imputed Income. Contributions for medical, dental and vision coverage for eligible dependents that do not meet the definition of a tax dependent will be made on a post-tax basis and the Imputed Income will be included on your paycheck and IRS Form W-2.

Newborn's and Mother's Health Protection Act

Federal law (Newborn's and Mother's Health Protection Act of 1996) prohibits the plan from limiting a mother's or newborn's length of stay to less than 48 hours for a normal delivery or 96 hours for a cesarean delivery or from requiring the provider to obtain pre-authorization for a stay of 48 hours or 96 hours, as appropriate. However, federal law generally does not prohibit the attending provider, after consultation with the mother, from discharging the mother or her newborn earlier than 48 hours for normal delivery or 96 hours for cesarean delivery.

The Women's Health and Cancer Rights Act

The Women's Health and Cancer Rights Act requires group health plans that provide coverage for mastectomy to provide coverage for certain reconstructive services. This law also requires that written notice of the availability of the coverage be delivered to all plan participants upon enrollment and annually thereafter. This language serves to fulfill that requirement for this year.

Annual Notices (continued)

These services include:

- Reconstruction of the breast upon which the mastectomy has been performed;
- Surgery/reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment for physical complications during all stages of mastectomy, including lymph edemas.

In addition, the plan may not:

- Interfere with a participant's rights under the plan to avoid these requirements; or
- Offer inducements to the healthcare provider, or assess penalties against the provider, in an attempt to interfere with the requirements of the law.

However, the plan may apply deductibles, coinsurance, and co-pays consistent with other coverage provided by the Plan.

Genetic Information Nondiscrimination Act (GINA)

The Genetic Information Nondiscrimination Act (GINA) applies to the City of Killeen Group Health Plan. This new law establishes a basic, uniform national standard to protect the public from discrimination based on genetic information.

Continuation Required by Federal Law for You and Your Dependents

Federal law enables you or your dependent to continue health insurance if coverage would cease due to a reduction of your work hours or your termination of employment (other than for gross misconduct). Federal law also enables your dependent(s) to continue health insurance if their coverage ceases due to your death, divorce, legal separation, or with respect to dependent children, failure to continue to qualify as a dependent. Continuation must be elected in accordance with the rules of your employer's group health plan(s) and is subject to federal law, regulations and interpretations. For additional information, contact the Human Resources Department.

Medicaid and the Children's Health Insurance Program (CHIP) Offer Free or Low-Cost Health Coverage to Children and Families

If you or your children are eligible for Medicaid or CHIP and you are eligible for health coverage from your employer, your State may have a premium assistance program that can help pay for coverage. These States use funds from their Medicaid or CHIP programs to help people who are eligible for these programs, but also have access to health insurance through their employer. If you or your children are not eligible for Medicaid or CHIP, you will not be eligible for these premium assistance programs.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, you can contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, you can contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or **www.insurekidsnow.gov** to find out how to apply. If you qualify, you can ask the State if it has a program that might help you pay the premiums for an employer-sponsored plan.

Once it is determined that you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must permit you to enroll in your employer plan if you are not already enrolled. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**.

If you live in one of the following States, you may be eligible for assistance paying your employer health plan premiums. The following list of States is current as of January 31, 2014. You should contact your State for further information on eligibility.

ALABAMA – Medicaid	**KANSAS – Medicaid**
Website: http://www.medicaid.alabama.gov Phone: 1-855-692-5447	Website: http://www.kdheks.gov/hcf/ Phone: 1-800-792-4884
ALASKA – Medicaid	**KENTUCKY – Medicaid**
Website: http://health.hss.state.ak.us/dpa/programs/medicaid/ Phone (Outside of Anchorage): 1-888-318-8890 Phone (Anchorage): 907-269-6529	Website: http://chfs.ky.gov/dms/default.htm Phone: 1-800-635-2570
ARIZONA – CHIP	**LOUISIANA – Medicaid**
Website: http://www.azahcccs.gov/applicants Phone (Outside of Maricopa County): 1-877-764-5437 Phone (Maricopa County): 602-417-5437	Website: http://www.lahipp.dhh.louisiana.gov Phone: 1-888-695-2447
COLORADO – Medicaid	**MAINE – Medicaid**
Medicaid Website: http://www.colorado.gov/ Medicaid Phone (In state): 1-800-866-3513 Medicaid Phone (Out of state): 1-800-221-3943	Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html Phone: 1-800-977-6740 TTY 1-800-977-6741
FLORIDA – Medicaid	**MASSACHUSETTS – Medicaid and CHIP**
Website: https://www.flmedicaidtplrecovery.com/ Phone: 1-877-357-3268	Website: http://www.mass.gov/MassHealth Phone: 1-800-462-1120
GEORGIA – Medicaid	**MINNESOTA – Medicaid**
Website: http://dch.georgia.gov/ Click on Programs, then Medicaid, then Health Insurance Premium Payment (HIPP) Phone: 1-800-869-1150	Website: http://www.dhs.state.mn.us/ Click on Health Care, then Medical Assistance Phone: 1-800-657-3629

IDAHO – Medicaid and CHIP	MISSOURI – Medicaid
Medicaid Website: www.accesstohealthinsurance.idaho.gov Medicaid Phone: 1-800-926-2588 CHIP Website: www.medicaid.idaho.gov CHIP Phone: 1-800-926-2588	Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005
INDIANA – Medicaid	**MONTANA – Medicaid**
Website: http://www.in.gov/fssa Phone: 1-800-889-9949	Website: http://medicaidprovider.hhs.mt.gov/clientpages/clientindex.shtml Phone: 1-800-694-3084
IOWA – Medicaid	**NEBRASKA – Medicaid**
Website: www.dhs.state.ia.us/hipp/ Phone: 1-888-346-9562	Website: www.ACCESSNebraska.ne.gov Phone: 1-800-383-4278
NEVADA– Medicaid	**NEBRASKA – Medicaid**
Medicaid Website: http://dwss.nv.gov/ Medicaid Phone: 1-800-992-0900	Website: http://www.scdhhs.gov Phone: 1-888-549-0820
NEW HAMPSHIRE – Medicaid	**NEBRASKA – Medicaid**
Website: http://www.dhhs.nh.gov/oii/documents/hippapp.pdf Phone: 603-271-5218	Website: http://dss.sd.gov Phone: 1-888-828-0059
NEW JERSEY – Medicaid	**NEBRASKA – Medicaid**
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medic aid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710	Website: https://www.gethipptexas.com/ Phone: 1-800-440-0493
NEW YORK – Medicaid	**UTAH – Medicaid and CHIP**
Website: http://www.nyhealth.gov/health_care/medicaid/ Phone: 1-800-541-2831	Website: http://health.utah.gov/upp Phone: 1-866-435-7414
NORTH CAROLINA – Medicaid	**VERMONT– Medicaid**
Website: http://www.ncdhhs.gov/dma Phone: 919-855-4100	Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427
NORTH DAKOTA – Medicaid	**VIRGINIA – Medicaid and CHIP**
Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-800-755-2604	Medicaid Website: http://www.dmas.virginia.gov/rcp-HIPP.htm Medicaid Phone: 1-800-432-5924 CHIP Website: http://www.famis.org/ CHIP Phone: 1-866-873-2647
OKLAHOMA – Medicaid and CHIP	**WASHINGTON – Medicaid**
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: http://hrsa.dshs.wa.gov/premiumpymt/Apply.shtm Phone: 1-800-562-3022 ext. 15473
OREGON – Medicaid and CHIP	**WEST VIRGINIA – Medicaid**
Website: http://www.oregonhealthykids.gov Phone: 1-877-314-5678	Website: www.dhhr.wv.gov/bms/ Phone: 1-877-598-5820, HMS Third Party Liability
PENNSYLVANIA – Medicaid	**WISCONSIN – Medicaid**
Website: http://www.dpw.state.pa.us/hipp Phone: 1-800-692-7462	Website: http://www.badgercareplus.org/pubs/p-10095.htm Phone: 1-800-362-3002
RHODE ISLAND – Medicaid	**WYOMING – Medicaid**
Website: www.ohhs.ri.gov Phone: 401-462-5300	Website: http://health.wyo.gov/healthcarefin/equalitycare Phone: 307-777-7531

Medicare Part D Notice

IMPORTANT NOTICE FROM THE CITY OF KILLEEN ABOUT YOUR
PRESCRIPTION DRUG COVERAGE AND MEDICARE

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with The City of Killeen and about your options under Medicare's prescription drug coverage. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. This information can help you decide whether or not you want to join a Medicare drug plan. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.

2. The City of Killeen has determined that the prescription drug coverage offered by the City of Killeen is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join a Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th through December 7th. However, if you lose creditable prescription drug coverage, through no fault of your own, you will be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

What Happens to Your Current Coverage if You Decide to Join a Medicare Drug Plan?

If you decide to join a Medicare drug plan, your current The City of Killeen coverage will not be affected. Your current coverage pays for other health expenses in addition to prescription drugs. If you enroll in a Medicare prescription drug plan, you and your eligible dependents will still be eligible to receive all of your current health benefits.

If you do decide to join a Medicare drug plan and drop your current The City of Killeen coverage, be aware that you and your dependents may not be able to get this coverage back.

Medicare Part D Notice (continued)

When Will You Pay a Higher Premium (Penalty) to Join a Medicare Drug Plan?

You should also know that if you drop or lose your coverage with The City of Killeen and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

For More Information About This Notice Or Your Current Prescription Drug Coverage…

Contact the person listed below for further information. NOTE: You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through The City of Killeen changes. You also may request a copy of this notice at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage…

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage:

⇒ Visit www.medicare.gov

⇒ Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help

⇒ Call 1.800.MEDICARE (1.800.633.4227). TTY users should call 1.877.486.2048.

Remember: Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and whether or not you are required to pay a higher premium (a penalty).

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 1.800.772.1213 (TTY 1.800.325.0778)

Date:	**August 1, 2015**
Name of Entity:	**The City of Killeen**
Contact:	**Catherine Mathes, Benefits Specialist**
Address:	**101 N. College Street** **Killeen, Texas 76541**

Phone Number: 254-501-7837

Marketplace Information

1. **What is the "Exchange" or "Marketplace" that I've been hearing about?**
   A The Exchange/Marketplace is a new health insurance marketplace in each state. The Marketplaces are established under the Healthcare Reform Act that was passed in 2010. The Marketplace is an on-line site where individuals and smaller employers may go to purchase health insurance coverage for 2014.

2. **Q Why is the Marketplace being established?**
   A Under federal law, beginning January 1, 2014, individuals will be required to have minimum essential health coverage, or else be subject to a penalty. This is referred to as the "individual mandate." The Marketplace is intended to help individuals meet the individual mandate requirement by providing another place to purchase coverage, and possibly qualify for federal assistance to do so.

3. **Q Do I have to purchase health coverage through the Marketplace?**
   A No. You may still obtain health coverage from other sources if you are eligible. To avoid the individual mandate penalty, you will want to confirm that the coverage you obtain provides "minimum essential coverage" under the rules.

4. **Q What are some possible other sources of coverage?**
   A Your employer, your spouse's employer, Medicare (if eligible in your state), the individual market, etc.

5. **Q What if I am covered under my employer's plan? Can I keep it?**
   A Yes. Most employer plans will qualify as the coverage required under the individual mandate requirements. You do not need to purchase coverage through the Marketplace in order to avoid the individual mandate penalty. You may, if you would like, however.

6. **Q Can I drop myself or my dependents from my group plan to purchase a plan through the Marketplace or outside of the Marketplace?**
   A Maybe yes. Maybe no. Employers and Marketplaces have very specific rules around enrollment and disenrollment. In general, both have an annual open enrollment period (which will usually be different) and permit special enrollments during the year based on events such as marriage or birth of a child. Although these rules are similar, they are not identical. In addition, determining when you can change an election outside the annual open enrollment period will be determined by IRS regulations and the terms of the group health plan. Generally, employees may not change an election unless the employee experiences a change in status permitted by the IRS and allowed by the group health plan.

Marketplace Information (continued)

7. Q How do I know if I qualify for assistance to purchase my coverage through the Marketplace?

A Individuals who are not offered qualifying healthcare coverage through their employer may be eligible for government subsidies to help pay for health insurance premiums for plans purchased in the Marketplaces (based on income level and how many dependents you have). Generally, household income must be below 400% of the federal poverty level (which in 2014 is about $46,000 for an individual, or about $78,000 for a family of three), in addition to some other rules, in order to qualify. Whether you qualify will depend on what kind of coverage your employer offers. If your job-based coverage is considered affordable and meets minimum value requirements, you won't be able to get lower costs on premiums or out-of-pocket costs in the Marketplace. This is true no matter what your income and family size are. As state Marketplace sites are launched over the next months, you will be able to get details about a possible subsidy.

8. Q Will my employer subsidize my health coverage if I purchase it through the Marketplace?

A Employers are not required to help you pay for coverage that you purchase through the Marketplace. With most employer-provided plans, the employer pays a portion of the premium cost. You should consider this when making decisions about where to obtain your health coverage.

9. Q Will I be able to see my same doctor if I purchase coverage through the Marketplace instead of at work?

A Maybe yes. Maybe no. Insurance purchased through the Marketplace may have different provider networks.

10. Q When will the Marketplace in my state be open for business?

A Open enrollment in the Marketplaces is scheduled to begin October 1, 2014, with coverage to generally become effective January 1, 2016. Please refer to the Marketplace in your state for further information.

11. Q Do I have to enroll by January 1, 2016, in order to get coverage through the Marketplace?

A No. In this first year of Marketplace coverage, you may enroll until March 31, 2015. But if you enroll after December 15th of this year, your coverage will have an effective date that is later than January 1, 2015. To avoid not having coverage beginning January 1, 2015, and potentially incurring a penalty, you should enroll by December 15, 2014, if you wish to satisfy the individual mandate with coverage obtained through the Marketplace.

12. Q Will my employer's health benefits program be available for purchase through the Marketplace?

A Possibly, if your employer is considered to be a small employer under the rules, and has chosen to purchase its program for employees through the Marketplace. Generally, employers with over 100 employees, or in some states 50 employees, may not purchase their programs for employees through the Marketplace yet. Employers of any size may offer coverage through regular channels, however, just as they do today.

Marketplace Information (continued)

Alabama	http://marketplace.cms.gov/
Alaska	http://marketplace.cms.gov/
Arizona	http://marketplace.cms.gov/
Arkansas	http://www.hbe.arkansas.gov/
California	http://coveredca.com/
Colorado	http://www.connectforhealthco.com/
Connecticut	http://www.accesshealthct.com/
Delaware	http://dhss.delaware.gov/dhcc/
District of Columbia	http://healthreform.dc.gov/DC/Health+Reform
Florida	http://marketplace.cms.gov/
Georgia	http://marketplace.cms.gov/
Hawaii	http://www.hawaiihealthconnector.com/
Idaho	http://www.doi.idaho.gov/HealthExchange/SBEBlueprint.aspx
Illinois	http://insurance.illinois.gov/hiric/hie.asp
Indiana	http://marketplace.cms.gov/
Iowa	http://www.insuranceinfoexchange.iowa.gov/
Kansas	http://marketplace.cms.gov/
Kentucky	http://healthbenefitexchange.ky.gov/Pages/home.aspx
Louisiana	http://marketplace.cms.gov/
Maine	http://marketplace.cms.gov/
Maryland	http://marylandhbe.com/
Massachusetts	https://www.mahealthconnector.org/portal/site/connector
Michigan	http://marketplace.cms.gov/
Minnesota	http://www.mn.gov/hix/
Mississippi	http://marketplace.cms.gov/
Missouri	http://marketplace.cms.gov/
Montana	http://marketplace.cms.gov/
Nebraska	http://marketplace.cms.gov/
Nevada	http://exchange.nv.gov/
New Hampshire	http://www.nh.gov/insurance/consumers/fedhealthref.htm
New Jersey	http://marketplace.cms.gov/
New Mexico	http://www.nmhia.com/nmhix/
New York	http://www.healthcarereform.ny.gov/health_insurance_exchange/
North Carolina	http://marketplace.cms.gov/
North Dakota	http://marketplace.cms.gov/
Ohio	http://marketplace.cms.gov/
Oklahoma	http://marketplace.cms.gov/
Oregon	http://coveroregon.com/
Pennsylvania	http://marketplace.cms.gov/
Rhode Island	http://www.governor.ri.gov/healthcare/message/
South Carolina	http://marketplace.cms.gov/
South Dakota	http://marketplace.cms.gov/
Tennessee	http://marketplace.cms.gov/
Texas	http://marketplace.cms.gov/
Utah	http://www.avenueh.com/
Vermont	http://healthconnect.vermont.gov/
Virginia	http://marketplace.cms.gov/
Washington	http://wahbexchange.org/
West Virginia	http://bewv.wvinsurance.gov/
Wisconsin	http://marketplace.cms.gov/
Wyoming	http://marketplace.cms.gov/

Glossary of Health Coverage and Medical Terms

This glossary has many commonly used terms, but isn't a full list. These glossary terms and definitions are intended to be educational and may be different from the terms and definitions in your plan. Some of these terms also may not have exactly the same meaning when used in your policy or plan, and in any such case, the policy or plan governs. (See your summary of Benefits and Coverage for information on how to get a copy of your policy or plan document.)

Allowed Amount
Maximum amount on which payment is based for covered health care services. This may be called "eligible expense," "payment allowance" or "negotiated rate." If your provider charges more than the allowed amount, you may have to pay the difference. (see Balance Billing.)

Appeal
A request for your health insurer or plan to review a decision or a grievance again.

Balance Billing
When a provider bills you for the difference between the provider's charge and the allowed amount. For example, if the provider's charge is $100 and the allowed amount is $70, the provider may bill you for the remaining $30. A preferred provider may not balance bill you for covered services.

Co-insurance
Your share of the costs of a covered health care service, calculated as a percent (for example, 20%) of the allowed amount for the service. You pay co-insurance plus any deductibles you owe. For example, if the health insurance or plan's allowed amount for an office visit is $100 and you've met your deductible, your co-insurance payment of 20% would be $20. The health insurance or plan pays the rest of the allowed amount.

Complications of Pregnancy
Conditions due to pregnancy, labor and delivery that require medical care to prevent serious harm to the health of the mother or the fetus. Morning sickness and a non-emergency caesarean section aren't complications of pregnancy.

Co-payment
A fixed amount (for example, $35) you pay for a covered health care service, usually when you receive the service. The amount can vary by the type of covered health care service.

Deductible
The amount you owe for health care services your health insurance of plan covers before your health insurance or plan begins to pay. For example, if your deductible is $1000, your plan will not pay anything until you have met your $1000 deductible for covered health care services subject to the deductible. The deductible may not apply to all services.

Durable Medical Equipment (DME)
Equipment and supplies ordered by a health care provider for everyday or extended use. Coverage for DME may include: oxygen equipment, wheelchairs, crutches or blood testing strips for diabetics.

Emergency Medical Condition
An illness, injury, symptom or condition so serious that a reasonable person would seek care right away to avoid severe harm.

Glossary of Health Coverage and Medical Terms (continued)

Emergency Medical Transport
Ambulance services for an emergency medical condition.

Emergency Room Care
Emergency services you get in an emergency room.

Emergency Services
Evaluation of an emergency medical condition and treatment to keep the condition from getting worse.

Excluded Services
Health care services that your health insurance or plan doesn't pay for or cover.

Grievance
A complaint that you communicate to your health insurer or plan.

Habilitation Services
Health care services that help a person keep, learn or improve skills and functioning for daily living. Examples include therapy for a child who isn't walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology and other services for people with disabilities in a variety of inpatient and/or outpatient settings.

Health Insurance
A contract that requires your health insurer to pay some or all of your health care costs in exchange for a premium.

Home Health Care
Health care services a person receives at home.

Hospice Services
Services to provide comfort and support for persons in the last stages of a terminal illness and their families.

Hospitalization
Care in a hospital that requires admission as an inpatient and usually requires an overnight stay. An overnight stay for observation could be outpatient care.

Hospital Outpatient Care
Care in a hospital that usually doesn't require an overnight stay.

In-network Co-insurance
The percent (for example, 20%) you pay of the allowed amount for covered health care services to providers who contract with your health insurance or plan. In-network co-insurance usually costs you less than out-of-network co-payments.

In-network Co-payment
A fixed amount (for example, $15) you pay for covered health care services to providers who contract with your health insurance or plan. In-network co-payments usually are less than out-of-network co-payments.

Medically Necessary
Health care services or supplies needed to prevent, diagnose or treat an illness, injury, condition, disease or its symptoms and that meet accepted standards of medicine.

Glossary of Health Coverage and Medical Terms (continued)

Network
The facilities, providers and suppliers your health insurer or plan has contracted with to provide health care services.

Non-Preferred Provider
A provider who doesn't have a contract with your health insurer or plan to provide services to you. You'll pay more to see a non-preferred provider. Check your policy to see if you can go to all providers who have contracted with your health insurance or plan, or if your health insurance or plan had a "tiered" network and you must pay extra to see some providers.

Out-of-network Co-insurance
The percent (for example, 40%) you pay of the allowed amount for covered health care services to providers who do not contract with your health insurance or plan. Out-of-network co-insurance usually costs you more than in-network co-insurance.

Out-of-network Co-payment
A fixed amount (for-example, $30) you pay for covered health care services from providers who do not contract with your health insurance or plan. Out-of-network co-payments usually are more than in-network co-payments.

Out-of-Pocket Limit
The most you pay during a policy period (usually a year) before your health insurance or plan begins to pay 100% of the allowed amount. This limit never includes your premium, balance-billed charges or health care your health insurance or plan doesn't cover. Some health insurance or plans don't count all of your co-payments, deductibles, co-insurance payments, out-of-network payments or other expenses toward this limit.

Physician Services
Health care services a licensed medical physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine) provides or coordinates.

Plan
A benefit your employer, union or other group sponsor provides to you to pay for your health care services.

Preauthorization
A decision by your health insurer or plan that a health care service, treatment plan, prescription drug or durable medical equipment is medically necessary. Sometimes called prior authorization, prior approval or precertification. Your health insurance or plan may require a preauthorization for certain services before you receive them, except in an emergency. Preauthorization isn't a promise your health insurance or plan will cover the cost.

Preferred Provider
A provider who has a contract with your health insurer or plan to provide services to you at a discount. Check your policy to see if you can see all preferred providers or if your health insurance or plan has a "tiered" network and you must pay extra to see some providers. Your health insurance or plan may have preferred providers who are also "participating" providers. Participating providers also contract with your health insurer or plan, but the discount may not be as great, and you may have to pay more.

Premium
The amount that must be paid for your health insurance or plan. You and/or your employer usually pay it monthly, quarterly or yearly.

Glossary of Health Coverage and Medical Terms (continued)

Prescription Drug Coverage
Health insurance or plan that helps pay for prescription drugs and medications.

Prescription Drugs
Drugs and medications that by law require a prescription.

Primary Care Physician
A physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine) who directly provides or coordinates a range of health care services for a patient.

Primary Care Provider
A physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine), nurse practitioner, clinical nurse specialist or physician assistant, as allowed under state law, who provides, coordinates or helps a patient access a range of health care services.

Provider
A physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine), health care professional or health care facility licensed, certified or accredited as required by state law.

Reconstructive Surgery
Surgery and follow-up treatment needed to correct or improve a part of the body because of birth defects, accidents, injuries or medical conditions.

Rehabilitation Services
Health care services that help a person maintain, get back or improve skills and functioning for daily living that have been lost or impaired because a person was sick, hurt, or disabled. These services may include physical and occupational therapy, speech-language pathology and psychiatric, rehabilitation services in a variety of inpatient and/or outpatient settings.

Skilled Nursing Care
Services provided from licensed nurses in your own home or in a nursing home. Skilled care services are from technicians and therapists in your own home or in a nursing home.

Specialist
A physician specialist focuses on a specific area of medicine or a group of patients to diagnose, manage, prevent or treat certain types of symptoms and conditions. A non-physician specialist is a provider who has more training in a specific area of health care.

UCR (Usual, Customary and Reasonable)
The amount paid for a medical service in a geographic area based on what providers in the area usually charge for the same or similar medical service. The UCR amount sometimes is used to determine the allowed amount.

Urgent Care
Care for an illness, injury or condition serious enough that a reasonable person would seek care right away, but not so severe as to require emergency room care.

2015-16 Benefit Guide and
2015-16 Quick Reference Guide
also available online at:

- The City of Killeen Public Drive
- City of Killeen website
  Human Resources Department
  www.killeentexas.gov
- Web Benefit Design website
  www.mybensite.com/killeen